Substance Misuse Management in General Practice (SMMGP)

Towards a Primary Care Network

July 2000 Newsletter No. 17

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Opportunities and Threats to the Management of Drug Users in Primary Care

Our recent RCGP conference *Managing Drug Users In General Practice* on the 11-12th May, was an opportunity to review the last year as a time of enormous change for those of us working with drug users in primary care. The new 'Drug Misuse and Dependence - Guidelines on Clinical Management' arrived. They have helped support 'shared care' and stated very clearly that drug users have a right to care like any other patient. They have also given GPs a framework to do this work. Conversely they come with a veiled threat of discipline if doctors step outside these guidelines, and have the potential of restricting prescribing options. They hint of further restrictions and control on prescribing to come.

The Home Office has very recently sent out the first draft of their proposed licensing document. If this is not adapted, I believe it will confirm the end of the 'British System' and severely restrict the treatment of drug users in primary care.

Previously, UK Drug Policy has had a public health approach. Its aim was to help drug users to lead healthier lives and limit the damage caused by drugs, to themselves or others. It was very easy for primary care to understand its role. Since 1997 the policy has moved away from health improvement and harm reduction and focused on the link between drugs and crime. Primary care appears to be less clear where it fits into this new agenda.

These recent documents could be seen to be working against the last 10 years of harm reduction in this country. The link with the criminal justice agenda is set to increase and it could move primary care into more of a 'policing' role rather than one of health care providers.

Drugs Tsar Commitment to Primary Care at RCGP Conference

Keith Hellawell, the UK Anti-Drugs Co-ordinator, spoke of his personal commitment to community treatment as a central part of overall strategy, and of the valuable role of primary care in treating drug users. He said he came not to lecture, but to support and acknowledge primary care. Mr Hellawell was addressing delegates at the RCGP conference *Managing Drug Users in General Practice* on 12th May in Leeds. He also acknowledged capacity concerns, and stated that treatment received a greater input through criminal justice rather than health last year, due to clearer criminal justice funding requirements given to ministers. He was hopeful that following this year's Comprehensive Spending Review, more money could be directed to health given greater clarity of requirements.

Fear has also entered the arena of caring for drug users in general practice. The arrests of two prescribing GPs in Cumbria and Essex have added to this fear. One of these GPs has now been acquitted of all charges. The history of these arrests is still far from clear, but what are the scope and limitations of police interests in the treatment of drug users?

Sadly some people involved in GP politics have used developing policies and these events as reasons to suggest that prescribing to drug users should be decamped back into the specialist services. This has tended to be parties who were never happy with the idea of 'normalising' drug users care in primary care and have been supported by particular elements of the reactionary medical press.

These moves are against what many of us have been trying to achieve. The annual RCGP conferences on the management of drug users in general practice, this SMMGP newsletter and the budding primary care network, the expansion of primary care facilitation and the increase of good, safe and supported shared care schemes show that many are willing. There are many other developments as well; the flourishing growth of local drug users groups, the National Drug Users Network and the rise of special interest groups such as the Methadone Alliance, Action on Hepatitis C and the Pharmacists Working in Substance Misuse Group.

Many workers, doctors and others working in primary care and drug users being treated in primary care are committed to taking this work forward and need on-going support and resources. We may need to join forces to travel through this period of change. **Dr Chris Ford**¹ If you have not received the special *SMMGP Bulletin 1, Support for Clinicians Following GP Arrests – Information for GPs Who Work With Drug Users*, contact SMMGP. Contact details on page 8.

The RCGP conference moved to a one and a half-day format this year with extra sessions intended to attract delegates new to the field or just getting their feet wet. A broad range of policy, operational and clinical issues were covered including: 'The Strategy'; public health and criminal justice/safety; models of care; doing research and the evidence base for what we do (see p.3); Hepatitis C (see p.4) and much more. The conference was over-subscribed and seemed as popular and passionate as ever, even attracting our first heckler! This newsletter and the budding primary care network received positive feedback. The conference consensus statement is on page 5. Full conference reports will be available from the RCGP Courses Unit 020 78239703 later in the year. Come along in 2001!

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Supervised Consumption A Balanced Approach Supporting and Respecting Patients

Of all the recommendations contained in the latest edition of the Clinical Guidelines on the treatment of Drug Misuse, it is probably the ones relating to supervised consumption that have attracted the most comment on the part of professionals and patients alike.

It has pre-occupied user-led organisations such as my own, the Methadone Alliance – going as it does to the heart of the issue of whether or not drug users can and should be treated in much the same way as other patients. On the one hand, some have denounced supervised consumption as a breach of a patient's human rights; on the other hand, it has been hailed as the simple answer to the problem of 'diversion' and poor compliance. Each of these statements make valid points, but to me they oversimplify what is a rather more complex dynamic.

Supervised consumption clinics – where patients spend long periods of time taking methadone under direct observation – originated in the U.S more than thirty years ago. Methadone treatment was permitted to exist there only on condition that the mechanisms of control for programmes were elaborate and zealously enforced. Not only are methadone clinics in the States subject to extensive federal regulation, but they are also regulated by each individual state. And we are not talking here about a set of clinical guidelines – but an enormous number of specific and complex regulations that govern almost every activity.

Whilst the welfare of the patient may have figured in the equation somewhere, there was sometimes a hidden agenda to make methadone difficult and tiresome to access. It was hoped that this would give patients an extra 'push' to get them off the stuff. Supervised consumption has also given a 'soup-kitchen' image to many methadone programmes – perpetuating a general impression that patients in such programmes are likely to be pretty dodgy people.

So I don't think it will come as a surprise to readers that I explicitly condemn such regulated systems that deny doctors the ability to use their clinical judgement and treat patients like long-term prisoners because of their need for methadone treatment. If methadone is about anything, its is about helping opiate users to normalise their lives, and going to a clinic every day to take medicine just isn't very 'normalising'.

Such strict programmes can also discourage people from staying in treatment. In Italy, there was a period of some years in the early 1990's when take-home doses of methadone were explicitly forbidden. The whole Italian system went over to blanket supervised consumption.

Recently, researchers in Italy have gone back to the records from those years and compared drop-out rates from treatment during that period with matched samples of patients from the present day. The paper makes interesting reading for people who are worried that supervised consumption could increase drop out rates.

But is this what is being suggested over here in the UK when we speak about supervised consumption? I don't think so. I don't think more than a small minority of professionals would want to see such programmes emulated here in the UK.

The UK Guidelines make it clear that supervised consumption should not carry on longer than is necessary. It is not supposed to be a 'blanket' system – but a way of giving more support to drug users being inducted into methadone programmes. The Guidelines give explicit exemption to people who work and those for whom supervised consumption would be impossible – for instance because of the distance they would have to travel each day.

Given the outcry about deaths of young people from methadone poisoning and the corrosive effect that has had on service development, I can understand why the Guidelines group felt they had to take some action in response. Sadly, the matter seems to have proved so contentious in the group that the eventual recommendation ended up pleasing nobody!

I believe that the Guideline's recommendations on supervised consumption are a sensible and balanced response that should enable users to be more safely inducted onto methadone. The first few weeks of methadone treatment is a vulnerable time for most users – and we do them no service if we just provide drugs with little support. It also seems to me that a period of supervised consumption gives the physician more confidence in using higher doses. We still under-dose many methadone patients – and then we wonder why they are not responding better to treatment!

And there's another important point. One of the things stopping the expansion of methadone treatment to more people who might benefit from it is the perceived threat to communities from illicit methadone. Yes - at times this gets played up – particularly by people who are affronted by the whole notion of substitute prescribing - who just do not like the idea of addicts getting what they see as their 'sweeties' so easily. These people are not going to go away – and we play into their hands if we are not seen to respond to such concerns.

In the end – what is important is that there is the opportunity for patients to be treated like any other patient with a chronic condition. In the States, this just isn't possible. One size has to fit all. But this need not happen here.

I know that many users can be treated in normal primary care settings, to their great benefit. But drug users can lose control of their drug taking - and sometimes do. Drugs can and do get into the hands of other people, and over the past few years this has caused a number of deaths. We have to respond to this but without disadvantaging patients who are responding well to treatment.

So it seems to me that our challenge is to construct a UK-wide methadone system that has reasonable checks and provides a high level of support for the first few weeks or months of treatment. However, it must also be able to provide individualised care that allows patients who are responding well to treatment to come out of more intrusive programmes and receive their care in the same way as many other patients with chronic conditions.

Bill Nelles General Secretary, The Methadone Alliance Tel: 020 8374 4395

¹Take Home and Compliance with Methadone Maintenance Treatment - Pani and Pirastu; in Heroin Addiction and Related Clinical Problems 2000; 2(1): 33-38

Comprehensive Literature Review and Bibliography: Treatments for Opiate Users in a Primary Care Setting Gabbay M, Jeffrey V and Carnwath T.

Introduction: The drug strategy for the United Kingdom outlines a shift of emphasis away from reacting to the consequences of drug misuse to tackling its root causes. It has a multi-disciplinary focus, bringing together agencies including health authorities, local authorities, police forces, the Prison Service, Probation, Customs and Excise, the National Crime Squad and Drug Action Teams. Representatives from these agencies will collaborate to form a new body named the UK Anti-Drugs Strategic Steering Group and a systematic and comprehensive appraisal of the strategy's impact is to be carried out every three years.

There is an increasing emphasis on underpinning service delivery with the best available evidence. There are a variety of sources for this, such as the Cochrane collaboration, Bandolier etc. The process of conducting a systematic review can be complex and expensive, particularly in a field such as this where few of the journals are included in the bibliographic databases such as Medline, or available in libraries¹.

As part of the Trafford CDT based SRB funded 'Enhancing Shared Care in Greater Manchester' project, we have conducted a comprehensive literature review, which is shortly to be published. The review evaluates the effectiveness of treatment programmes from a primary care perspective, in relation to two of the aims set out in Tackling Drugs to Build a Better Britain. Namely the reduction of anti-social and criminal behaviour, and enabling people with drug problems to overcome them and to live healthy and crime free lives (in terms of retention in treatment, illicit drug use, criminal activity and employment).

The review summarises the published evidence, and identifies important gaps in knowledge. It is not a formal Cochrane style systematic review. Our aim was to be inclusive, and review the wide breadth of available literature, rather than focus on those fulfilling stricter quality criteria, which would have excluded much of the published research. The review takes a more informal approach, and summarises the methodology, findings and limitations. The bibliography summarises 390 references, 340 of which are included in the review. The following is a very condensed overview of our conclusions.

Main conclusions from published evidence Methadone maintenance - Individuals enrolled on a methadone maintenance programme show good retention in treatment, but outcome is more successful when ancillary services are provided. A dose of at least 50 mg is required to prevent illicit drug use most effectively, however dosage does not affect the use of non-opiates. Methadone is more effective if collected daily for some users, however this does have implications for primary care resources. Enrolment on a programme does enhance employment prospects.

Methadone reduction - Whilst this method has gained acceptability for many years, and is the standard to compare new approaches against, there is little research evidence into its effectiveness, particularly in outpatient and community settings. For example retention in treatment has only been examined in one study (1977) that showed a retention rate of 63%, and a 1986 one which found a 17% regime completion rate in outpatients

at 8 weeks. Illicit drug use has only been investigated in one study. The extent of criminal activity and employment prospects have not been examined.

Non-methadone maintenance - Buprenorphine demonstrated the best retention rates of approximately 55%, compared to 34% seen with LAAM; a retention rate not as effective as methadone. However LAAM maintenance led to a better attendance than methadone. At least eight milligrams of buprenorphine is required to maintain this, and 80 mg of LAAM. Use of both buprenorphine and LAAM promoted a decline in illicit opiate use, however buprenorphine maintenance also enabled a decline in cocaine use in some studies. Buprenorphine on the whole was most effective for those individuals with a high level of psychosocial functioning. No studies examined criminal activity or employment prospects.

Non-methadone reduction - Of all the pharmacological treatments reviewed, buprenorphine, clonidine and lofexidine have shown positive results. Naltrexone or naloxone in combination with clonidine or lofexidine may also be effective, although research data is still limited. Buprenorphine has shown better completion rates than clonidine and naltrexone, but gradual reduction is most effective. There is insufficient published evidence to make reliable comparisons between these treatments with regard to for illicit drug use, criminal activity and employment, but generally buprenorphine produced results as good as methadone. There are no large-scale published trials of lofexidine regimes in the community, although a small RCT has shown some benefits over clonidine.

Heroin - Heroin maintenance research demonstrated a reduction in criminal activity and retention in treatment, but not in the use of illegal drugs, or an improvement in social functioning.

Psychotherapeutic approaches - All treatments examined showed better results if counselling was used as an adjunct, although counselling alone did not prove effective. There is some evidence that those with additional mental health problems benefit most (except certain more severe personality disorders). On balance, the literature suggests that the amount and frequency of such a programme should vary according to individual client need and progress.

Complementary therapies - There is a need for further research into the role of complementary therapies in alleviating opiate withdrawal.

Report summary - The report is in two parts, a review of the evidence concerning a wide variety of available treatments for opiate users in a community setting, plus an extensive bibliography. The work is based on a systematic literature review. The bibliography refers to in excess of 300 references, many of which are summarised. The work provides a comprehensive literature survey and provides information to enhance decisions on service commissioning and provision. It will be published later this year, and expressions of interest may be made to *Tracy Jenkinson at Trafford CDT* on 0161 912 3175 or by e-mail to mbg@liv.ac.uk. I would also recommend a recent Australian literature review, although it is not specifically focussed on community treatments is also an excellent research summary.

Mark Gabbay Senior Lecturer in General Practice Department of Primary Care, Liverpool University

- Gabbay M (Ed) The evidence-based primary care handbook. 1999 Royal Society of Medicine Press London.
- Ward J, Mattick RP, Hall W Methadone maintenance treatment and other opioid replacement therapies 1998 Harwood Amsterdam.

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Hepatitis C

What do we know? HCV is an RNA virus, first isolated in 1989, and probably accounts for most of the cases of what were previously termed "Non A Non B" hepatitis. There are currently 6 major subtypes, 1-6, and these have been further sub-divided. This sub-typing is useful for epidemiological purposes, and some types can be associated with a worse prognosis e.g. types 1a & 1b

- The main route of transmission is PARENTERAL, i.e. blood to blood.
- Intravenous drug use estimated that 50 80 % of injecting drug users are HCV positive
- Blood transfusion prior to Sept 1991 (since then all donated blood is screened)
- Body piercing; Tattoos; Wet shaving low risk
- Transmission via sex is low, 5% lifelong transmission from sexual partner
- Vertical transmission during childbirth is uncommon,
 5% known
- · HCV is not transmitted via breast-feeding

Presentation

Acute Hepatitis is uncommon, and most of these occur post transfusion. Incubation period is 5 - 12 weeks. Symptoms: mild malaise, jaundice in 25%. Rarely - fulminant hepatitis. In 50% of all cases there is progressive liver damage. In 30 – 40% of all cases the person may be unwell and unable to work because of tiredness and general malaise.

Chronic Hepatitis C accounts for most cases and usually occurs 10-30yrs after initial infection. Patients may be asymptomatic, but many suffer from non-specific fatigue which can be very debilitating. Aches and pains and itching can also be associated with HCV infection. Occasionally the disease is more aggressive, with vasculitis, glomerulonephritis etc.

Testing - Before testing it is essential that time is taken to discuss the implications with the client, and what a positive or negative result would mean to them. It is also important to use this as an opportunity to advise them about safer injecting and protecting themselves and others. If testing is carried out, the result should be given during a consultation usually by the same person who did the test, and not over the telephone. It is wise to avoid Fridays as a time to give results - they may well need a lot of support in the first few days post result, together with on-going further information and support.

- ELISA Enzyme linked immunosorbant assay; detects antibodies to HCV
- RIBA- Recombinant immunoblot assay; used as confirmatory test if ELISA reactive
- PCR- Polmerase chain reaction; tests for amount of actual virus present
 NB. Although most seroconvert in 8-12 weeks, it can take up to 6 months

After initial confirmation other tests may be carried out e.g. LFT's, and referral for, liver ultrasound, liver biopsy if the patient wants to pursue treatment. Always check Hepatitis B status and vaccinate if necessary.

Prevention of transmission - Don't share needles, syringes, and paraphernalia. Avoid sharing razors, toothbrushes, scissors etc. Appropriate disposal of tampons. Condoms use, especially if multiple partners. (Discuss risks in stable relationship). This will also reduce risk of co- infection with HIV and Hepatitis B (which can worsen prognosis) and other types of Hepatitis C. Inform dentist, GP etc.

Alcohol Although the mechanism of liver damage is unclear alcohol is an aggravating factor. It is of prime importance that clients are aware of this, and that they receive help and support as necessary to enable them to stop drinking.

The size of the problem - WHO estimate that HCV infection affects 3% of the world population, but the true figure is not known.

Disease progression - It is estimated that 15% recover spontaneously; 25% remain symptom free with benign histology; 60% have chronic hepatitis, 20% of which develop cirrhosis. Some will go on to end-stage cirrhosis. A small number will develop liver cancer. However, these are estimates, and more research is needed to determine the size of the problem and also the extent of HCV related morbidity and mortality.

Treatment - The two main treatments used are Interferon and Ribavirin. Treatment with Interferon alone is successful in clearing the virus in 25%. Results are better with combination therapy (about 50%), but both treatments have potentially debilitating side effects. It is also unclear as to whether or not clearing the virus indicates long term cure or whether it is temporary.

There are also difficulties in deciding who is appropriate for treatment. Liver biopsy can be difficult to interpret, and in deciding whether to treat or not, all the test results must be considered together, along with the views of the client. **Dr Alison Field** (contact details p.5)

Action on Hepatitis C

Action on Hepatitis C was formed in 1999 out of deep professional and service user concern at the lack of an overall government strategy to address the problem of drug misuse and hepatitis C. This concern is in the face of the UK's hepatitis C epidemic, and despite pressure from professionals from many different backgrounds, the failure to progress this issue through normal channels for over six years.

There are many issues that urgently need to be resolved at a national level:

- There is no national strategy to combat the hepatitis C epidemic
- The epidemic is not being properly assessed or monitored
- Estimates of numbers need to be formulated. Present range is 200,000 (DoH) & 600,000 (hepatologists)
- · There are no projections for the future
- There are no additional resources to cope with affected people in the UK

Prevention

- It is important to continue & expand needle exchanges
- Recent figures from Scotland show a marked increase in numbers of young injectors becoming infected
- If treated, hepatitis C induced liver cancer could be considerably prevented

Treatment

- There are marked inequalities of treatment example of postcode medicine
- · Treatment will incur savings as well as costs

The hepatitis C epidemic is a medical issue, a humanitarian issue and a human rights issue, which is currently being disregarded by officialdom.

For information on Action on Hepatitis C contact: Tom Waller, Chair, Action on Hepatitis C, PO Box 92, Woodbridge, Suffolk IP12 4QY, Fax 01473 736550.

Working with Hepatitis C in

Primary Care The St. Martin's Practice Experience

The practice has an 'active' caseload of 80 - 100 patients at any one time, and our figures for those affected by HCV infection is approximately 70% of injecting drug users. Following initial diagnosis it was originally our practice to refer straight to our local liver unit at St. James' Hospital, Leeds. However, it soon became apparent that the DNA rate from our clients was high. This was partly to do with the practical difficulties in getting appointments to people who frequently change address, and also due to generally chaotic behaviour. In addition to this there was clearly a lot of anxiety about going to hospital and in particular about the prospects of a liver biopsy.

In order to try and address these difficulties the practice team met with our hepatology consultants and the liaison nurse from the unit, and over time have developed a joint protocol. This includes the development of patient information leaflets about the hospital procedures, which we discuss with them before deciding on whether or not to refer. If a referral is made, the appointment time is sent to the practice so that we can inform the client. The necessary further blood tests are taken at the practice and the results go to the consultant prior to the first

Therapeutic Input Needed With Prescribing in Primary Care

My practice, Freedom Health Centre, with a solo GP principal (myself) and a one-day a week assistant GP, has over the last fifteen years, built up a system, largely using shared-care principles, for approximately 300 IV users, almost half of whom are in some kind of therapeutic support. There is a wide range of treatments available in Plymouth which include a specialist service widely known for its generous prescribing policy, a nonstatutory agency which offers harm-minimisation treatments, and several in-patient abstinence-based services run on rehabilitative lines. In spite of this, I have become alarmed, over the last five years, at the growing sizeable minority of clients who have tried one or all of these means of treatment with a singular lack of success and disillusionment. Furthermore, government policy and even organisations such as SMMGP have, in my view, concentrated mainly on issues around drug therapy and the effects of illegal substances without looking adequately at the underlying, intrapsychic difficulties that these clients quite clearly have. With a co-worker, Heather Watt, who is an accredited BAC therapist, I have experimented with a service which now offers 20 hours of therapeutic time per week simply looking at patterns of substance use (including alcohol) with associated lifestyle and experiences as a symptom rather than the cause. Using a psychodynamic approach and flexible co-counselling, particularly when issues of medical importance arise in sessions, this style of care has proved amazingly successful in terms of measure of personal growth and consequent lifestyle adjustment. Not surprisingly, though not necessarily at an early stage, the majority of the 70 clients have begun to reduce their substitute medication in a progressive but stable way. Use of chemicals to alter reality as a way of escaping conflict is seen as a result of the continuation of patterns of behaviour which often have their roots in infancy and childhood. We plan to continue this service for the foreseeable future despite absence of funding.

Dr Hugh Campbell

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consultation. Funding for the tests comes from the hospital. This means fewer visits to the hospital, and the patients are better prepared. Although the scheme is in its infancy, it is apparent that those who have been referred since its introduction are attending their appointments, and are certainly better informed. Further review will be necessary to determine its effectiveness.

We have also set up a Hepatitis C support group which is held once a month at the practice, and which is facilitated by our Addiction therapist and one of our attached health visitors. Although the numbers are still small they are increasing, and it is well received by those who attend.

HCV infection is a cause of significant morbidity and may be life threatening. Although treatment is limited, an awareness of the diagnosis can help prevent spread, and patients can make changes to their own behaviour to improve their prognosis. A heightened awareness of the problem by those working in Primary Care, and in particular by those who work with drug users, is essential, and clearly funding for ongoing research is necessary.

Dr Alison Field - St Martin's Practice 319 Chapelton Road, Leeds LS7 3JT 0113 262 1013

Therapeutic Input - In our September issue we will review some models for delivering therapeutic input in primary care. This will include motivational interviewing.

Comments and contributions welcomed

RCGP Conference Consensus Statement

Leeds 11th - 12th May 2000 (Continued from page 1)

Conference Statement 1

"This conference welcomes the increased involvement of primary care in services for drug users and the development of the Primary Care Network. In order to continue to develop this work primary care requires a commitment to training at all levels, increased resources for shared care and access to specialist support. The emphasis should be on equitable and rapid access to methadone maintenance and other evidence-based services.

Maintaining current levels of commitment in the primary care community requires urgent dialogue between the Department of Health and the profession, recognising the strong evidence-base underpinning drug treatment and methadone maintenance treatment in particular. Health professionals involved in this work should be held professionally accountable but should not be inappropriately targeted by the criminal justice system."

Conference Statement 2

We regret that there was only minimal consultation on the Home Office proposal for changes to the licensing regulations for doctors working in the field of drug misuse, and recommend that the consultation period should be extended and the proposal more widely circulated.

Managing Substance Misuse Patients in the Primary Care Setting

Most alcohol and many drug using patients can be managed by primary care teams. All patients have problems. One in 25 will have an underlying alcohol problem while one in fifty will have an underlying drug problem (Alcohol Concern, Britain's Ruin, May 2000). The skill is in spotting it and a GP will be doing well to recognise half of them. Just treating the presenting problems of the other half is not productive, but gives a breathing space and time to add up the clues.

Once identified, brief interventions are effective for those people whose drinking or using is above safe limits but not yet creating a dependency. GPs providing information and feedback on health matters have considerable influence on the behaviour of their patients. Practice nurses, using interventions such as motivational interviewing can be a useful resource to reduce the number of patients whose drinking or drug use might otherwise develop into a more intractable problem. Substance misuse counsellors deployed as part of the Primary Care Team, work with chemically dependent patients who need longer term counselling. Equally important is their role supporting the work of GPs and practice nurses and educating the whole team. GPs learn best on their patients and with support become increasingly confident of their ability to effect change.

The crux of the problem is what the patients want to do about it. If they do not want to make changes now it is important to be ready for a crisis which may provide a catalyst and meanwhile working with the family members and monitoring the situation will enable the primary care team to prepare for the right moment to intervene. GPs are accustomed to 'curing' their patients. Substance misusers can only be cured of the diseases caused by their inappropriate use of chemical substances, not the behaviour which is the underlying cause. The consequent sense of impotence created by the patient either denying the behaviour or demanding that the doctor should do something to change it, is considerable. It comes as some relief during motivational interviewing training, for GPs to realise that the responsibility for the 'cure' lies with the patient, not with the GP.

The interface between the counsellor and the GP raises two important issues, shared care and confidentiality. Shared care means that when a patient is referred to the substance misuse counsellor the patient's medical care is still with the GP who may wish to have relevant information from, or plan the management with, the counsellor. The counsellor will require the assistance of the GP to access residential detoxification facilities or instigate a home detoxification. Here, the confidentiality issues arise. GP confidentiality is team shared, of necessity since s/he is responsible over a long period, possibly a lifetime – for the patient and often the family and must give information to colleagues who will substitute in his/her absence. On the other hand counsellors are accustomed to sharing information only with specific consent of the patient. Shared care requires that the best interests of the patient should determine the extent to which information is passed and with consent of the patient. Implementation of 'Home and Dry', CADAs home detoxification protocol has provided the basis for the most effective shared care in the surgeries.

Reluctance on the part of a few practices to embrace the care of chemically addicted patients may stem from the chaotic and sometimes disruptive behaviour of this group

of patients and their time consuming demands on services. CADA's experience is that it is those people who are not offered a service who can be difficult to deal with in the surgery. Those who are, respect the boundaries set by the counselling contract, which includes the requirement that the patient does not drink or use before their appointment on that day. Where all surgeries provide a service, the fears that drug and alcohol dependent people will all rush to register with the few who do, are negated and GPs come to value the expertise they gain in the care of substance misusers.

Margaret Findlay - Director, Cornwall Alcohol & Drugs Agency, Infirmary Hill, Truro, Cornwall TR1 2HY

ALCOHOL- Guidelines for Primary Care

Alcohol dependence has enormous health and social costs to the individual, the family and society. It tends to be a chronic relapsing condition and treatment can be difficult. It is a common problem presenting to GPs.

Detoxification from alcohol in the community - Being able to detox a patient off alcohol at home, in the community, is a useful treatment tool which allows the patient to remain in there own environment.

Community detoxification – The drug of choice is Chlordiazepoxide (Librium) 10mgs. Diazepam can be used instead with equal results, but as it is so commonly prescribed to and used by people who use alcohol, it is preferable to use Chlordiazepoxide. Diazepam 10mgs = Chlordiazepoxide 20mgs

- The dose level and length of detox will depend on the severity of the alcohol dependence
- Nutritional / vitamin deficiency will be treated with multivitamins and / or thiamine at the same time.
- There needs to be some titration against the dose of alcohol that the client is using
- The regime needs to fit to individual need and symptoms

Criteria for community detoxification include:

- Stable accommodation
- Physically stable, they may have a chronic condition which is being treated, but this does not exclude them
- Health problems that are not stable will make them more appropriate for in-patient detox
- Motivated to receive treatment
- Supportive social infrastructure
- Psychiatric problems may not exclude clients from home detox if they are stable and well controlled

Chlormethiazole (Heminevrin) - It is <u>never acceptable</u> <u>to prescribe chlormethiazole as part of a community</u> <u>detox</u>. In overdose or in combination with alcohol, it can cause respiratory failure and death.

Maintaining abstinence - Detoxification is frequently successful, but maintaining abstinence is difficult. About 50% of alcohol patients relapse within 3 months of completing treatment. Work needs to be done to maintain the abstinence. This can take the form of counselling, relapse prevention groups and drugs such as acamprosate or disulfiram.

Other addictions - Many patients can also have addiction to other substances. Many drug users who present with a primary drug problem may be drinking to worryingly high levels. Many problem alcohol drinkers may also have a concurrent dug problem, especially benzodiazepines. Some clients may also have mental health problems and this must also be taken into consideration in the assessment and the care plan.

Adapted and shortened from SMP guidelines. Full guidelines from Chris Ford at SMP, Brent & Harrow HA, Bessborough Rd, Harrow, HA1 3EX - 020 89661109



Dr Fixit - Alternatives to Methadone

Problem: I have several drug users complaining that they don't like methadone and asking for an alternative. Are there any alternatives? And would I be 'colluding' with the patients by considering one? **Response:** Methadone is not universally popular with drug users and until recently there were few alternatives. Other drugs that are sometimes prescribed as alternatives, include dihydrocodeine which is unlicensed for the treatment of drug dependency (further information below) and diamorphine which requires a home office license to prescribe. However, recently two additional drugs have been licensed for the treatment of opiate dependency. Buprenorphine is an opiate antagonist/agonist which some users prefer to methadone and which can discourage use on top of a script as well as being safer in overdose (See Buprenorhine study below). At present the guidance is that buprenorphine should be instigated by specialists (but could be continued in general practice), so a specialist referral should always be sought. Levomethadyl acetate (LAAM) is a long-acting synthetic opioid which only needs to be taken three times a week. There is little experience of using this drug in the UK and there is minimal reference to it in the guidelines due to its unlicensed status at the time of writing. In summary there are alternatives to methadone but a specialist assessment should be sought before considering them.

Dihydrocodeine - DF118

The Home Office has put out new proposals for consultation which propose that all schedule 2 and 3 drugs with the exception of oral methadone should require a Home Office license to prescribe for the treatment of drug dependency. This would mean that the only substitute prescribing alternative to oral methadone available to unlicensed doctors would be dihydrocodeine (DF118). What are its' advantages and disadvantages?

The Pro's: It can retain patients in treatment who are not retained by oral methadone due to the fact that it is normally a shorter acting opiate with a definite 'buzz' to it (Longer acting DHC also exists). This can be particularly useful with younger users with shorter histories who may be less keen to stabilise on a long acting opioid. It is also often viewed more positively than methadone in local drug scenes where there can be a cultural resistance to methadone. There is little reported injecting of the tablets and it has a comparatively safe therapeutic toxicity profile. It has a shorter withdrawal syndrome which can be useful in detoxification. However, withdrawals may potentially be more intense

The Cons: The 'Buzz' it can give can maintain the mindset of looking for a high. Because it is normally a short acting and a relatively weak preparation, it can involve patients taking very large numbers of tablets a day. Unlike methadone it is not licensed for drug dependency treatment and thus no rigorous research has been done into its effectiveness. It is the most constipating of all the opiates and this could be a major issue in long term maintenance. It has not traditionally been the drug of choice in drug dependency treatment although drug treatment services have used it for particular patients in maintenance and detoxification on a needs led basis for the reasons outlined.

RCT of Dihydrocodeine and Methadone Treatments of Opiate Dependence

The 1999 National Guidelines highlighted the lack of evidence in many areas of drug treatment and drew attention to the need for a better evidence base on those treatments in current use. The use of dihydrocodeine as an alternative or a supplement to the more conventional and evaluated treatment of methadone mixture is an area that has required clarification for some years. At various consensus meetings it has been apparent that dihydrocodeine is widely prescribed by GPs, prison doctors and specialists as an adjunct or alternative to methadone. There are no official guidelines and no substantial reported studies either indicating how this preparation might be best used or evaluating outcomes.

Our RCT has been established and further funded by the Chief Scientist Office in order to try to test the efficacy of dihydrocodeine against that of methadone. The project will follow a large group of drug users over a prolonged period of time and measure those outcomes which have been previously used in methadone trials over many years. These outcomes include mortality and various morbidities, retention in treatment, use of other drugs and various other indicators. It is hoped that progress reports will be issued as we go along and that the outcome of the study may be to clarify the place of Dihydrocodeine in the treatment of opiate dependency. Dr Roy Robertson, Edinburgh Drug Addiction Study EDAS, 1 Muirhouse Avenue Edinburgh EH4 4PL 0131 332 2201 Fax: 0131 332 2984

Ed: For more information on Dihydrocodeine see John Macleod, Anne Whittaker, Roy Robertson. Changes in opiate treatment during attendance at a community drug service – findings from a clinical audit. Drug and Alcohol Review (1998) 17, 19-25

Buprenorphine Substitution Therapy for Opiate Dependency

A Prospective Multi-centre Study

SIRIUS – Schering-Plough Investigative Research into the Use of *Subutex* (Buprenorphine)

The SIRIUS project is intended to confirm the enhanced safety profile of Subutex when used in a large UK community setting. Over thirty years of use has provided physicians with a level of knowledge of methadone and this study will compare Subutex to methadone during the first six months of opiate substitution.

SIRIUS is conducted under the guidelines for company sponsored safety assessment of marketed medicines. As a non-randomised, non-interventional, observational design it collects information on adverse events and general health over the first six months of treatment.

Schering – Plough aim to recruit over 200 investigators from Community Drug Teams, Drug Dependency Units and from General Practice (over 100 have been recruited to date). From this investigator network, information on 5000 opiate dependent patients requiring opiate substitution therapy will be recorded.

Serious adverse events will be recorded with special attention drawn to both fatal and non-fatal overdose. General health will be recorded as a measure of adverse events. The Sirius Project will be the largest study of opiate substitution carried out in the UK.

Study Participation: Further information about participation in this study can be obtained from: Dr. Mark Lightowler Sirius Project Manager Schering-Plough Ltd Welwyn Garden City AL7 1TW Tel: 01707 363657 Fax:01707 363678 email: sirius.project@spcorp.com



Dr Fixit - Urinalysis

Question: Urinalysis gets debated regularly. But I am still rather confused as to its evidence base, and why, how, and when should it be done?

Answer: Urinalysis can be a useful tool when used appropriately. It can *help* confirm the range of drugs being used and is *useful as part of the process of confirming dependency*. It can help decide on the treatment plan and protect the patient from inappropriate prescribing. It is also essential for our medico-legal protection. It does not tell us the amount of drugs used or whether the use is increasing or decreasing.

Urinalysis can either be used therapeutically or punitively. We would always use it in the former way to help confirm dependency and help review the treatment plan. A non-punitive approach to treatment tends to promote honesty with or without urine screening. If urine screening is used as part of a non-punitive treatment approach, then it almost always confirms the drug history that the client has given. A review urine with someone on methadone which indicates positive for heroin, might suggest that an increase in dose was appropriate.

Many drug services still use urines punitively. Examples are 1. Three dirty urines and treatment is stopped 2. Two dirty urines and your prescribed drugs are reduced (It seems bizarre that if a patient is using on top, perhaps because the prescription is too low, that a common solution to this is to reduce the prescription).

Urine screening can be a controversial area and drug users groups, amongst others, suggest that urine testing has no evidence base as a therapeutic tool; that it hinders rather than helps in a therapeutic relationship; that the information it gives clinicians does not confirm anything of clinical value; that it is an undignified way to treat people; that it is an infringement of civil liberties. This formed the basis of the Black Poppy 'stop taking the piss campaign'.

In practice one will be putting oneself at risk if one does not do an initial test, and someone dies of an overdose. Also further risk could occur if supplies are found to be leaking on to the black market and no further random tests have been carried out. The clinical guidelines recommend urine testing before prescribing to help confirm opiate use, and random testing at least twice a year to ensure medication has been taken, and as part of the therapeutic process.

The times that drugs remain in the urine depends on the drug, the amount, the chronicity of use, whether it was taken with other drugs and or alcohol and the concentration of urine. A guide to times is found in chapter 3 page 25 in the 'clinical guidelines'. Always remember that these are approximate times and to take account of different half-lives of drugs.

So whether or not it is therapeutically indicated, one is well advised to follow the recommendations in the guidelines purely for your own protection. However one should take steps to ensure that testing is carried out in as dignified and confidential a manner as possible, attempted in a supportive manner as part of an honest open approach. If someone is found to be using additional drugs to their prescribed medication, this is an opportunity to improve patient engagement and interventions rather than leading to a termination of treatment.

Every area will have a pathology lab, which will do toxicology screens. If you want instant results you can purchase testing dipsticks from various companies (This is not meant as a recommendation for 'instant' prescribing. Having time for a planned response is usually preferable). If someone is found not to have morphine or methadone in their urines, a script should be discontinued. Bear in mind that false positive and negative results are possible so be prepared to do a second test if necessary.

Urine screening is not an exact science in terms of results and interpretation of results. A positive opiate result does not protect against overdose, guarantee dependency or guarantee that no diversion is taking place. An open, understanding, and supportive relationship with the patient may go a lot further in supporting both the patient and the GP in these areas.

SMMGP aims to:

1.Co-ordinate and develop a primary care network: Includes production and dissemination of newsletter and web-site to promote good practice. Putting people in touch with others who can assist or support.

2. Give advice and support: To develop primary care/shared care work. Telephone advice; visits and facilitation; information; networking to other experts/ help.

Need advice or support? Then contact us

Seconded Advisor - Jim Barnard has a temporary secondment to SMMGP (mid -July 2000 – March 2001) as Jean-Claude Barjolin will be going part-time. This will also help expand our advice and support work. Contact Jim via SMMGP below or directly on 0161 905 1544.

SMMGP PRODUCTION GROUP - SMMGP is edited by Jean-Claude Barjolin, Chris Ford, and Jim Barnard. The newsletter is produced with editorial and steering group input from: Dr Berry Beaumont, Dr Claire Gerada, Dr Jenny Keen, Don Lavoie & Brian Whitehead

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